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# *Some Common Causes of Obscure Ailments*

Notwithstanding the gigantic strides that have been made in recent years by medical science and practice, especially in the field of diagnostics, and the truly wonderful illumination that has been shed upon the dark places of the nature and causes of disease, the practitioner of medicine, who deals, not with theories, but with conditions, is painfully aware that there are still quite a number of obscure ailments which present a very puzzling problem, requiring all the resourcefulness of which he is possessed for their solution. It is all very well for the text-books to lay out beautifully charted plans and annotated blue-prints of every disease in the calendar, mapping out the pathology and the etiology and the symptomatology so patently that not even a sophomore in a medical school could make a mistake in diagnosis, or fail to recognize a condition when he met it. But the man in practice knows, to his sorrow, that he often meets with conditions that are not in the text-books; and, as a matter of fact, he never does encounter a case which stands out in clean-cut relief like the disease-descriptions he reads in his text-books.

This is especially true, and especially troublesome, in these days, when it is no longer sufficient to adapt one's treatment to a group of symptoms, but when one must uncover and treat underlying causes of disease. In spite of the discoveries of modern medical science, there are still a sufficient number of obscure ills to keep the busy practitioner guessing. And while experience and case reports from various parts of the field are continually furnishing clues to the solution of some of these problems, they do not receive the currency that they might, and should, and often fail to reach those who need them.

It is with the hope of contributing a little to the enlightening of some of these difficulties that we here present a few of the commoner causes of certain obscure conditions which the physician is called upon from time to time to diagnose and treat. There is nothing strange or startling in these pages; only a few practical suggestions, gathered from experience and literature, for working out diagnostic problems which are often very puzzling because they involve some unusual or

unconsidered relation between cause and effect. None the less, we trust they will be found of practical help to the reader.

## *INTESTINAL STASIS*

The role of the bowels and their function in health and disease has long been recognized,—and perhaps somewhat exaggerated. From time immemorial it has been a classical "first aid" measure, in practically every form of illness, to administer a purgative or a cathartic to "move the bowels," which is undoubtedly as rational and useful as it is historic. Certainly the accumulation of a mass of decomposing waste material in the intestines is not a desirable state of affairs, from any point of view, even in a person who is not ill; far less desirable in one who is under the handicap of a physical ailment. And, indeed, the scientific evidence of the medical man is not needed to establish this fact; every individual knows, of his own experience, how much better and brighter and more fit he feels after a good cleaning out of the bowels.

On the other hand, the importance of intestinal sepsis has unquestionably been greatly exaggerated by a certain school of clinicians, who have attributed almost every ill that flesh is heir to, and even some that do not exist at all, to intestinal autotoxemia, i. e., the absorption of fecal toxines from the intestinal tract. When one considers that by the time the contents of the intestinal canal reach the stage of decomposition they are in the lower bowel,—the colon and sigmoid, where little or no absorption takes place, it is plain that there cannot be any very great contamination of the blood-stream from this source. In colonic stasis continuing over many years it is quite possible, to be sure, that even the slight seepage that does take place, persisting for so long, may have a noticeable toxemic influence; but not of the extent so often ascribed to it.

Intestinal stasis, however, and especially colonic stasis, of a progressive and long-continued type, does have a decided and distinctive pathologic significance, and is the cause of certain obscure conditions which often baffle the diagnostician. The morbid element is not a toxic one, but a circulatory and nervous one. The splanchnic and colonic areas become a large cistern of more or less stagnant blood, in which, as a matter of fact, almost one-third of the entire volume of blood in the body is continually tanked. As a consequence, the blood pressure falls to an abnormally low point, the general circulation is slowed and depressed, the other organs of the body,

including the brain and the musculature, are deprived of blood, and a state of systemic asthenia and nervous irritation results.

Every physician encounters such patients. Their chief, and indeed their only complaint, is asthenia; they have no "pep", tire easily, cannot keep up with their work, readily take cold. They seem to be anemic, but a blood-count proves normal. They suggest focal infection, and as an experimental measure the doctor removes their tonsils, and their appendix, and their bad teeth; but they do not react. The possibility of tuberculosis, or syphilis, suggests itself; but the most searching investigation fails to confirm the suspicion. The urinalysis reveals nothing, except perhaps a low urea output. The only abnormal physical finding is a low blood pressure—often as low as 60 D. and 95 S.

If such a patient be submitted to an X-Ray examination, with a barium meal and the fluoroscope, it will frequently be found that the colon is of enormous size, sags under the weight of the barium until it almost rests on the pelvic floor, and does not empty itself for many, many hours,—sometimes for several days. And this, undoubtedly is the explanation of the whole trouble.

## *FOCAL INFECTIONS*

Of all the underlying causes of obscure ailments, undoubtedly the commonest is to be found in the existence, somewhere in the body, of a focus of bacterial infection; and in spite of the fact that this factor in disease has also probably been a little overdone, yet it is of such established frequency that the presence of an obscure disorder should always raise,—perhaps first of all,— the suspicion of a focal infection, and induce a thorough search throughout the body for such a focus. The search, however, should be systematic. The practice of ascribing any and every unexplainable ailment to an equally indefinite "focal infection," and making a wholesale sweep of tonsils, teeth, sinuses, appendices, and what-not, in a hit-or-miss effort to catch the offending focus, is both irrational and indefensible. It must be confessed that these foci of infection behave rather irregularly and vaguely, and are frequently difficult to identify and differentiate from the types of disorder that they produce. Nevertheless, there is a method in their madness; and a little observation and experience will furnish at least a clue to the nature and location of

infectious focus to be suspected in certain otherwise obscure conditions.

## *TONSILS*

These are one of the commonest seats of focal infection, and one of the most frequent sources of systemic disease,—so much so as to bear, very often, the blame and suffer the penalty for ills which they do not originate. Hence the wholesale, and often unnecessary, slaughter of tonsils since the doctrine of focal infection came into general recognition. Yet of all the focal infections, the systemic results of infected tonsils would seem to be the most characteristic, and the most readily identified. One has but to consider the function of the tonsils and the nature of their infections to understand this.

Practically all the infections which enter the system by way of the tonsils, or which incubate in the tonsils and are absorbed into the blood-stream, are of the type against which the tonsils are normally relied upon to safeguard the body, and toward which, therefore, the body itself, aside from the tonsils, has developed no tolerance or immunity. Hence every such infection, no matter how mild or chronic it may be in the tonsil itself, as soon as it gets into the blood-stream and becomes a systemic infection, is more or less acute in character; that is to say, it arouses, wherever it locates, the symptoms of more or less acute inflammation.

We say that the tonsils are the source, pre-eminently, of rheumatism. But, of course, rheumatism, in this sense, is simply the generic term which we apply to those infections (usually streptococcic) which most frequently originate in the tonsils and attack the serous linings of the joints, the heart, the muscle sheaths, etc. Unfortunately, this loose employment of terms leads to an indiscriminate association between the tonsils and so-called rheumatism in general. It is a mistake, however, to trace every type of rheumatism (so-called) to tonsillar infection; for there are numerous other focal infections which invade the joints and muscle-sheaths. It can almost be laid down as an axiom that only those types of rheumatism, or arthritis, which are quite decidedly inflammatory in character are traceable to tonsillar infections.

Affections of the joints and muscle-sheaths are, of course, not by any means the only ailments attributable to the tonsils. As stated, tonsillar infections also attack the lining

membranes of the heart; they also invade the eye, producing iritis and cyclitis; and no doubt many other acute streptococcic infections come from the tonsils which we are not in the habit of ascribing to them. The characteristic quality of all of them, however, is their acute inflammatory re-action. One of their diagnostic points is the invariable presence of a more or less marked leukocytosis in the blood-count.

## *TEETH*

Almost the exact opposite is true in the case of dental infections. The teeth are not normally bulwarks of protection against bacterial invasion. From the very outset a dental infection is more or less of a general infection, in which the defenses of the body take a part, although the seat of the battle is localized in the teeth. As a consequence, by the time that an infected tooth becomes a genuine focus of systemic infection, from which toxines seep into and through the system, a large degree of tolerance and immunity has been established, and there is no marked reaction of defense. Hence the ailments resulting from infected and ulcerated teeth are not, as a rule, acute, inflammatory lesions, but chronic, degenerative ones.

Infected teeth also produce a group of obscure diseases which go by the common name of rheumatism, or arthritis. They affect many of the same tissues and organs that tonsillar infections do,—the heart and cardiovascular system, the joints, the iris, etc. But they bring about, as a rule, an entirely different pathology, namely, a slow, insidious productive inflammation, usually fibrosis, so that we get, not an acute inflammatory rheumatism, or arthritis, or an acute endocarditis, but an arthritis deformans, an arteriosclerosis, a chronic myocarditis and the like. In the presence of this type of disorder, the teeth are the natural objects of suspicion, and, if infected teeth be discovered, it is justifiable to extract them.

Infected teeth give rise, of course, to rheumatic and neuritic pains and stiffness in the neck and shoulders, but this cannot be regarded as a remote or systemic manifestation of focal infection, but rather as a local congestion, due to contiguous influence, through the fifth and accessory nerves.

One of the not unfrequent consequences of infected teeth, none too commonly recognized, is a toxic condition of the musculature of the upper gastrointestinal tract, especially of

the stomach itself, made manifest in "stitchy" pains, particularly during digestion. The digestive process itself is not usually interfered with. Whether this is to be explained on the ground of contiguous influence, through the pneumogastric nerve, similar to stiff-neck, or as a remote toxemia, is an open question. Probably the former, since the pains resemble those of stiff-neck, and there appears to be no other pathology. In any case, it is an obscure condition, explicable by dental infection, and is cured by removal of the infected tooth or teeth.

## *INFECTED SINUSES*

What is true of infected teeth is also true of infected nasal sinuses, except that systemic infection from the sinuses is comparatively rare, owing to the walled-off topography of these structures. They are, therefore, to be suspected as the cause of systemic disorders when other more likely focal infections have been ruled out, or when the connection between the two is obvious.

Generally speaking, the resultant effects of sinus infections are to be seen in the structures and organs adjacent to the sinuses, by contiguity. Chief among these are affections of the eyes; and of these there are two groups: infections of the internal eye, and disturbances of the ocular muscles.

Many obscure cases of iritis, retinitis, choroiditis, etc., are in reality due to chronic infections of the ethmoid and sphenoidal sinuses. So, also, as intimated, are diseases of the internal eye the result of tonsillar and dental infections. From tonsillar infections the ocular results of sinus infection are, as a rule readily distinguished by the consideration already mentioned, namely, that tonsillar focal infections of the eye are usually acute, inflammatory lesions,—principally acute irites, while those from the sinuses are more often quiet, chronic diseases of the retina and choroid. It is not so easy to differentiate between those due to the sinuses and those due to the teeth, since they are in the same class. In this case, however, we have the therapeutic recourse; that is to say, we can first clean up whatever sinus infection may be present, since this entails no loss of valuable structures. If the eye condition then clears up, well and good. If not, suspected teeth can be extracted as a final resource. The main point to be made here is that infected sinuses do, in many instances, furnish the key to otherwise obscure diseases of the internal eye.

A much more common result of sinus infection is the occurrence of disturbances in the ocular muscles,—muscle imbalance, squint, etc. Indeed, many oculists are ready to say that in ***every*** case of squint occurring after childhood (except, of course, those due to organic nerve disease) an infection of the sinuses is the predominating cause. Even granting an error of refraction, they hold that this is only a contributory cause, and would not of itself produce a strabismus if there were not also a sinus infection. This is, perhaps, too extreme a view, ascribable to the enthusiasm of a specialist; but when every allowance has been made for that consideration, the truth is well established that sinus infection is one of the most fertile causes of strabismus and ocular imbalance, and the occurrence of either of these disturbances in the eyes of an adult, in whom no organic nerve disease can be demonstrated, calls for an investigation and possible treatment of the ethmoid or sphenoidal sinuses, or both. Moreover, sinus infections are much more widespread than the average practitioner suspects and accounts for a great many eye and head troubles, not only in the role of a focal infection but as a direct interference with the proper functioning of the nose. It may be emphasized, here, that by far the majority of ordinary headaches are the result of infections of the nasal sinuses and deflected nasal septums.

## *GALL-BLADDER INFECTION*

This may veritably be called the obscure cause of obscure disorders; for not only are the ailments which result from gall-bladder infection vague and indeterminate, but the infection itself is hidden from observation and hard to determine. Yet it is without question one of the commonest and most insidious forms of focal infection met with (albeit often unrecognized) in the practice of medicine. In it are involved two distinct kinds and modes of systemic infection,—first, the absorption and transmission to various parts of the body of the toxines and other products of bacterial invasion, and second, the resorption into the system of the bile pigments and excretory elements of the bile, notably cholesterin and lecithin, which are exceedingly poisonous.

As with the teeth, the bacteria which infect the gall-bladder are of a type to which the body has acquired tolerance and against which it makes little or no active defense. Indeed,

there are good reasons for believing that many gall-bladder infections have their origin in infected teeth; that is to say, they are secondary infections from pus-sacs in the roots of the teeth, and then become themselves foci of infection for the rest of the body, persisting after the infected teeth have been removed,—which explains why, in many cases, removal of infected teeth does not clear up systemic conditions which were apparently associated with them. The systemic conditions resulting from gall-bladder infections, therefore, like those resulting from infected teeth, are chronic, insidious conditions, attended by degenerative processes in the tissues they affect.

The tissues and organs attacked are practically the same as those involved in dental infection, namely, the cardiovascular structures and the joints, so that, so far as these symptoms are concerned, it is difficult to differentiate between the two underlying causes. As just intimated, both causes are frequently operative simultaneously and are inter-related. But not always. Many cases of degenerative myocarditis, arthritis deformans, and arteriosclerosis are due to chronic gall-bladder infection which may itself be so lacking in local symptoms as to be unsuspected.

If, however, these obscure conditions be really due to gall-bladder infection rather than to infected teeth, it will be made apparent by the accompaniment of another set of symptoms consequent upon the resorption of bile pigments and excretions. First there is the jaundice, which is probably important only as an index symptom. Whether the bile pigments are in themselves specially poisonous, or do any real injury, is a moot question. But at all events they color the skin and the mucous membranes, and serve as an indication that bile is being absorbed. As to the toxicity of the excretory elements, the cholesterin and lecithin, however, there is no question at all.

It is highly probable, by-the-way, that the profound systemic effects which have been erroneously attributed to intestinal stasis and sepsis are in reality the results of gall-bladder infection and the absorption of bile products. This is especially likely, since obstinate constipation is always one of the prominent attendants of gall-bladder infection. Here, unlike colonic stasis, we have the presence of exceedingly

toxic excretions, in fluid form, in the small, upper bowels, where absorption is rapid and plentiful.

The bile excretions are almost specifically toxic to the nerves and the nerve centres, irritating them badly,—so badly that in large quantities and high concentrations they even produce spasms and delirium. In ordinary gall-bladder cases, of course, they are not sufficiently absorbed to cause such profound nervous disturbances, but they produce these disturbances in kind, so that the patient exhibits noticeable nervous irritability, muscular twitchings, alternate somnolence and insomnia, etc. Moreover, they have a markedly destructive influence upon the blood-cells, so that there is a low blood count, both of reds and whites, and numerous petechial hemorrhages in the skin.

When, therefore, we encounter obscure cases of chronic arthritis, or myocarditis, or arterial fibrosis, or, in fact, any of the chronic conditions which point to a focal infection, accompanied by equally obscure nervous symptoms, the gall-bladder should be suspected as a probable focus, even though no definite signs of biliary trouble have ever manifested themselves, and a careful search made, by urinalysis, fecal examination, fluoroscopic observation, etc., for trouble in that organ. The so-called 50-50 white blood count, i. e. about an equal proportion of leukocytes and lymphocytes, is a strong indication of gall-bladder disease.

## *EYE-STRAIN*

To the late Dr. Geo. M. Gould belongs the credit of having discovered and taught that the nervous strain due to errors of ocular refraction can be, and frequently are, the cause of all sorts of nervous and functional disorders whose etiology had formerly been obscure and misunderstood.

The symptoms arising from any form of eye-strain are grouped under the general term Asthenopia, including the muscular symptoms directly associated with the use of the eyes themselves, and the remote symptoms in other parts of the body. The latter are all, in the last analysis, reflex in character, depending upon an excessive or unequal innervation of the eye muscles, and transmitted chiefly through the ocular and the fifth cranial nerves.

The ocular symptoms of asthenopia manifest themselves in inability to sustain a steady or prolonged use of the eyes, and by a more or less pain and discomfort when this is attempted.

The pain may be of any degree of severity, even to an agonizing neuralgia. At times there may be no actual pain at all, but after prolonged use of the eyes the vision becomes blurred and the patient grows sleepy or dizzy. If, in spite of the inconvenience, the patient forces himself to continue his work, he presently begins to develop positive signs of inflammation, such a photophobia, conjunctivitis, etc. Headache is a prominent symptom, to be briefly touched upon presently.

The functions of accommodation and convergence both belong to the class of nervous adjustments known as coordination. Under normal conditions, precisely the same amount of nervous discharge is required for the extrinsic muscles of each eye to hold the eyes balanced in proper convergence, and the same amount for each ciliary muscle to maintain equally focussed images on the two retinae. But if the refraction of the two eyes is different, then, in order to satisfy the demand for clear vision, one ciliary must contract more than the other; an unequal and unnatural innervation must be performed. In other words, coordination becomes an unnatural and extraordinary effort. Or suppose that the conditions of convergence are abnormal. The exercise of accommodation is, as we know, a normal and powerful stimulus to convergence. Hence, when, as in hyperopia or myopia, the normal relation between the two functions is disturbed, the natural tendency of convergence is to follow accommodation, which it is only prevented from doing by an unnatural innervation of the muscles concerned.

In either of these abnormal conditions, then, the nervous effort required to balance the muscles to the desired result is unnatural and extraordinary. But, as we know, the whole nervous organization of the body shares in the nervous discharge of any one function, and this is true in a special degree in the case of vision, which is so essential a factor in every act, emotion, or thought. Hence, any unnatural or extraordinary exercise of the nervous mechanism of vision cannot but make itself very quickly felt in an unnatural and extraordinary nervous impression upon other organs and functions. Thus it is that many cases of digestive and nervous disorder are caused by eye-strain, and may be cured by the proper fitting of glasses, which correct the refractive error, render the eyes normal, and equalize innervation.

The organs most closely associated with the ocular nerves are those of digestion; hence the commonest systemic dis-

turbances resulting from eye-strain are those of the stomach and intestines,—lack of appetite, dyspepsia, nausea, vomiting, constipation, etc. Next to these come disturbances of the general nervous system, such as chorea, neurasthenia, bed-wetting, insomnia, and even epilepsy. Dizziness is always a more or less noticeable symptom of eye-strain, because it is by the unconscious estimate we make of the amount of nerve energy expended in accommodation and convergence that we largely make our visual judgments, and when these faculties are unnaturally exercised dizziness inevitably results.

By far the commonest result of eye-strain, of course, is headache, which assumes various forms. In the main, the headache of asthenopia is usually of one of two types: (a) a brow headache, very much resembling that of nasal catarrh, due to hyperopia, (b) an occipital headache, extending into the back of the neck, with tender spots upon the scalp, due to astigmatism. (Myopia does not give headache). But, as a matter of fact, any character and location of headache may be an expression of eye-strain.

The prime differentiating point is time and circumstance of the headache. From headache due to systemic disease,—infection, nephritis, etc.,—the diagnosis is, of course, made by means of urinalysis, blood count, and other general diagnostic measures. The real crucial differentiation has to be made between ocular headache and headache due to nasal or sinus disease; and here time and circumstance are the diagnostic factors. The headache of eye-strain is directly related to the use of the eyes, it disappears during sleep, is absent on awaking in the morning, and comes on again during the latter part of the day. Nasal and sinus headache, on the other hand, has no relation to the use of the eyes, is worst in the morning on awaking, (due to congestion during the horizontal posture of sleep), and disappears or improves after being up and around for a few hours, because in the upright position drainage re-establishes itself. A headache with these features,—present every morning on awaking, and improving around ten or eleven o'clock—is almost invariably a nasal or sinus headache.

The same circumstantial test may, of course, be applied to digestive and other troubles resulting from eye-strain, namely, that they are directly related to the use of the eyes, and disappear during ocular rest; but not so unfailingly as in the case of headache.

## *VENEREAL DISEASE*

Venereal disease as a potential underlying cause of obscure disorders is, of course, universally recognized nowadays, so that there would hardly seem to be any need for referring to it in a brochure of this kind. However, there are two or three instances, perhaps, which still call for notice and emphasis.

### *Gonorrhea*

The remote effects of gonorrhea really belong under the heading of focal infections; they differ from ordinary focal infections, pathologically, in being the definite products of specific bacteria, and clinically, in that there is usually a clean-cut, open history of gonococcal invasion. Because of the specificity of the germ, the disorders resulting from focal gonococcemia, like those of tonsillar infection, are always acute and inflammatory in their character. In gonorrheal cases, indeed, this feature is even more marked than it is in tonsillar cases. For the rest, the gonococcal focal infections greatly resemble the tonsillar ones, and it is often very difficult to determine which of the two etiologies is involved in a given case. They attack much the same groups of tissues and organs, and produce much the same pathological pictures.

Gonorrheal Arthritis. The gonococcus has a special propensity for attacking the lining membranes of joints, in which it produces an extremely painful, acutely inflammatory arthritis, with considerable swelling and effusion. In this respect, of course, it does not differ from the germs of tonsillar infection, except, perhaps, that being a specific germ it is more typical and constant in its pathology, and usually more virulent. It is particularly prone to attack the joints of the extremities,—the wrist, ankle, fingers, and arch of the foot. Moreover, it is a more productive process, as a rule, than the tonsillar forms of arthritis, giving rise to considerably more fibrosis and absorption in the joint structure, and not so amenable to treatment as tonsillar rheumatism.

The systemic signs of active infection are always very marked. Usually, but not invariably, a rise in temperature, rapid pulse, and all the other symptoms of fever; always a noticeable increase in the leukocyte count.

Gonorrheal Endocarditis. Gonococcal infections, like those from the tonsils, also attack the serous linings and the muscles of the heart; but, contrary to the joint infections,

these cardiac results of gonorrhea are usually less violent and destructive than those of tonsillar origin. Also they are rarer. The heart structures seldom escape invasion by tonsillar rheumatism, to some degree or other; but in gonococcal infections they are frequently untouched. Furthermore, when the heart is involved, the cardiac involvement is practically always secondary to joint involvement. Gonorrhea almost never attacks the heart structures alone. An acute focal infection of the heart, therefore, without joint involvement, points strongly to a tonsillar or other streptococcic origin rather than to a gonococcal etiology. When all is said, however, the differentiation between the arthritis and endocarditis of tonsillar infection and those of gonococcal origin is exceedingly difficult to make, and we must here content ourselves with pointing out that gonorrhea is a frequent cause of these inflammatory conditions of obscure etiology.

In all cases of focal infection due to the gonococcus, the focus, or breeding place of the germs, will most frequently be found to be the prostate in the male and the uterine cervix in the female. Cumberbatch and Robinson, of London, have recently reported conclusive instances of inflammatory arthritis in women cured by the application of diathermia to the infected cervix in which the gonococcus had been demonstrated.

### *Syphilis*

Syphilis is even more generally recognized as a cryptic cause of obscure disease than is gonorrhea. It is, indeed, a clinical axiom that syphilis may and does simulate every disease in the calendar; and every physician has well implanted in his mind the maxim, When in doubt look for syphilis. The Wassermann test is an almost routine part of every diagnostic procedure that makes any pretensions to thoroughness. Yet, in spite of all this, there are a few conditions in which, for some reason or other, even after every other etiology has been canvassed in vain, syphilis seems to evade suspicion, notwithstanding it has been conclusively demonstrated that syphilis can and does produce these very conditions.

One of these is gastritis, or perhaps one had better say, gastrodynia. In spite of his general admission that syphilis can attack any organ in the body, and simulate any other disease in the catalog, the physician hardly ever thinks of the possibility that disorders of the stomach can be due to

syphilis. Yet it has been conclusively shown (especially by Hoover) that syphilis is occasionally the cause of stomach pathology.

In the stomach, as in many other parts, syphilis behaves symptomatically very much like cancer, and may, in the beginning, be mistaken for the incipient stage of malignancy. Anorexia, nausea, vomiting, pain, deficiency in hydrochloric acid, and dyspepsia, may all be present, and functionally, indeed, the patient may be a very sick individual, losing weight and strength because of malnutrition. The features of the case which point suspiciously to syphilis rather than to malignancy are: the irregularity and changeableness of the conditions, characteristic of syphilis everywhere, there being nothing constant or typical about the case; the fact that, in spite of the seriousness of the trouble, it does not steadily progress to that profound organic gravity which marks carcinoma; and the absence of the rapidly growing tumor,—although, to be sure, there may be a syphilitic mass.

Another condition which may owe its origin to syphilis, but which is scarcely thought of in connection with that disease, is entero-colitis. The association is more frequent than that of gastritis. There can be no doubt that quite a few cases of chronic enteritis and entero-colitis which are attributed to tuberculosis, but which do not attain the gravity of tuberculous disease, are in reality syphilitic in their etiology. As with the stomach, so in the intestines, syphilis simulates the graver disease, and gives practically the same symptomatology as tuberculosis, except for the irregularity and atypicallity of the symptoms, and the fact that the case lacks the distinguishing earmarks of a tubercular infection.

It is not to be understood that syphilis is a frequent or a common cause of either stomach or intestinal disorder. On the contrary, it is an infrequent and uncommon cause of these ailments. But when they are due to the commoner and well-recognized causes, these are easily diagnosed. It is when, in the presence of a gastrodynia or an entero-colitis, one cannot establish the classical etiology, that the disorder becomes obscure; and it is in such cases that one does well to remember syphilis as a possible underlying cause.

A positive Wassermann reaction aids, of course, in establishing the syphilitic diagnosis; but it should never be for-

gotten that a Wassermann reaction may be positive and yet the patient be suffering from other diseases besides syphilis. The only dependable confirmation of our suspicions of syphilis lies in the therapeutic test. If the ailment yields quickly and favorably to anti-syphilitic therapy, then we may be reasonably sure that we are dealing with a luetic infection.

## *THE ENDOCRINES*

Some of the grosser manifestations of defective endocrine glands have been known to, and recognized by, the medical profession for many years. Cretinism, for instance, as a result of deficient thyroid, has long been a familiar clinical entity. The symptom-complexes known as hyperthyroidism and hypo-thyroidism, and due, respectively, to excess and deficiency of thyroid secretion, are household pictures to every practising physician. And there are other examples, not quite so definite or clean-cut perhaps, but still generally recognized as being expressions of endocrine imbalance, such as the neuro-circulatory disturbances of puberty and the menopause. There still remain several other obscure conditions, not so generally recognized, which have their origin in a lack of balance between the various endocrine elements of the body. It is probable, indeed, that they are more numerous than any of us realize, and the number of those which are definitely traceable to this cause will undoubtedly increase each year as we learn more about the matter. We will mention only two here, as being of considerable clinical importance.

Metrorrhagia in young girls. Not infrequently we find young girls in whom the menstrual function has recently become established flowing for excessively long periods, and sometimes continuously, without any assignable cause. A little careful observation will disclose that these patients are of one of two types: either they are of the cretinic type, inclined to be thick and heavy, with plentiful coarse hair on the body, and rather dull mentally, or else they are precisely the opposite, disposed to be tall and underweight, with sparse, fine hair, mentally bright, even to precocity, but easily fatigued. The first type represents thyroid deficiency, the latter thyroid excess. In the former, one may encounter either amenorrhea or metrorrhagia, but more frequently amenorrhea. In the latter, it is always metrorrhagia, if any disturbance at all.

There are, to be sure, several other possible causes for uterine bleeding, even in young girls. But uterine bleeding (menorrhagia) and excessive menstrual flow (metrorrhagia) are two entirely different and distinct things, and must not be confounded. Ordinarily it is a perfectly simple matter to distinguish between them, because metrorrhagia is periodical, like menstruation itself, and has a definite relation to the monthly period, however prolonged it may be, while menorrhagia is erratic, and bears no relation whatever to periodicity. In case the bleeding is continuous, so that it is not possible to establish any periodicity, then the differentiation between metrorrhagia and menorrhagia must be made by an examination of the discharge. In sheer uterine bleeding, it will be found to consist of more or less pure blood, with, of course some slight admixture of epithelium and hyaline substance; in metrorrhagia it will disclose all the elements which go to make up a true menstrual secretion.

Whenever true metrorrhagia is demonstrated in young girls, endocrine imbalance, especially thyroid imbalance, is to be suspected as the cause before all others.

Neuro-Musculo-Circulatory Asthenia. Not infrequently we meet with patients who are structurally normal, to all appearances; that is to say, their height and weight are normal, as are also all their organs, no stigmata of defectiveness are visible on their bodies, and certainly no evidences of any definite disease are discoverable; yet they exhibit a generally low state of nervous, muscular and circulatory function. They are pale and inert, their temperature and blood pressure are both below normal, their heart action weak and sluggish, and they are an easy prey to every kind of ailment that comes along, except, strange to say, acute infections, which they rarely take.

Their condition is, in fact, very similar to that which has already been described under intestinal stasis, except that no particular stasis, or sagging, or dilatation of the colon can be demonstrated. Such cases are almost always examples of endocrine deficiency and imbalance,—possibly deficiency of the pituitary and adrenal glands, but more likely a general inadequacy of all the endocrine organs. A series of tests of their reaction to the various endocrine extracts will determine which are below par.

The principal clinical significance of this type of asthenia is that it not infrequently complicates other ailments, so that the patient does not respond to ordinary treatment for the ailment in question until, in addition, we apply endocrine therapy to supply the lack of the deficient internal secretion.

## *THE HEART*

It is a well-recognized fact that digestive and other troubles often complicate heart disease, and in many cases produce symptoms which are easily mistaken for heart disease; and there are cases where the eradication of a source of chronic infection has resulted in the disappearance of all cardiac symptoms without any further treatment. On the other hand, it is equally true that symptoms of digestive disturbance and even symptoms suggestive of focal infection frequently arise from heart disease, and that the treatment of the cardiac condition results in a disappearance of all these collateral symptoms without any further treatment.

It is probable, indeed, that more cases of heart lesion are wrongly diagnosed and treated as digestive and other troubles than the other way about, and with more serious consequences to the patient. Soda and bitters are frequently given, with little or no benefit, where a little intelligent treatment of the heart would promptly clear up the case.

In the case of acute indigestion this is fairly well understood by the medical practitioner. Whatever the newspapers may say in their frequent reports of the death of this and that noted person from "acute indigestion," the medical man knows that this usually means acute heart disease; and he knows that this is true in his own practice among his own patients. In the case of milder, chronic digestive disorders the truth is not so well recognized; but the relationship between the heart and the gastrointestinal function is precisely the same, in kind, in the chronic as in the acute case; indeed, the strong probability is that in all cases that suddenly develop a violent acute attack there has been a chronic condition of cardiac indigestion pre-existing for a long time.

Every case of indigestion in a young adult or a middle-aged person which is definitely associated with cold and exercise should raise a suspicion of heart disease, and call for a thorough investigation of the cardiovascular system.

In this connection it may here be pointed out that under the newer conception of the heart and its disorders the existence of a murmur is no longer of the essential import that it used to be in evaluating the condition of the heart. A heart with a very pronounced murmur may be in a much better functioning condition than one which shows no murmur at all. The crucial factors are (a) the conduction property of the cardiac muscle, which expresses itself in the rhythm of the heart, and (b) the state of the myocardium, which is evinced in the force of the heart-beat.

The advent of the electrocardiograph has given us the means of detecting irregularities in the heart rhythm (arrhythmias) at a very early stage of their development, when as yet they are not discernible by means of pulse palpation, and of differentiating the different types of arrhythmia. And the sphygmograph, or better still the polygraph, enables us to ascertain the working condition of the myocardium with considerable accuracy. In cases of obscure indigestion, and other gastrointestinal dysfunction, where ordinary examination of the heart gives no evidence of its involvement, it is well to submit the patient to the diagnostic observations of the electrocardiograph and the polygraph.

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